Healthpoint

Information from the Division of Health Care Finance and Policy

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CAN SOME AFFORD TO PAY MORE FOR COVERED HEALTH SERVICES?

All insured people incur out-of-pocket expenses for health care, but the nature, extent and burden of these expenses vary significantly. A recent study found that substantial medical bills contributed to more than half of the nation's personal bankruptcies in 1999, even though the majority of those individuals had some type of health insurance.[1] On the other hand, the American Society of Plastic Surgeons reported a 198% increase from 1992 to 2000 in the number of cosmetic surgeries—elective surgeries not covered by insurance.[2]

While the popular perception is that out-of-pocket spending for health care greatly increased in recent years, careful analysis shows that this is not so, even when elective spending is included. This *Healthpoint* examines trends in elective health expenditures, and provides evidence that some people have the capacity to assume greater responsibility for the cost of the covered medical services they use.

Increase in Health Care Costs Modest for Most

An article in *Heath Affairs*[3] analyzing Consumer Expenditure Survey (CES)[4] data, concluded that for those with employer based insurance, total out-of-pocket spending (employee contribution to premium, copays, deductibles and payments for uncovered services) increased only 4.2% from 1990 to 1997 (see table). A 23% decrease in out-of-pocket spending (primarily in medical care) largely offset a 29% rise in the employee contribution to premium. Since many employers deduct the employee contribution on a pre-tax basis while copays and deductibles are paid after taxes, this trade-off generally benefited tax-paying employees.

Consumer Expenditure Survey 1990, 1997

	1990	1997	% change
Total Direct Expense	$512	$396	-23%
Medical	$360	$260	-28%
Drugs	$140	$128	-9%
Premium Expense	$532	$684	29%
Total Expense	**$1,040**	**$1,084**	**4.2%**

Source: Bureau of Labor Statistics via Gabel and Ginsburg

The transition to managed care in the 1990s played a large role in reducing out-of-pocket non-premium spending. Use of copays rather than coinsurance, and coverage of preventive care (both hallmarks of managed care) contributed to this reduction. In 1997, households in HMO/POS plans spent 5% less on premium contributions than those in indemnity plans, but even more significantly, spent 41% less on out-of-pocket medical and drug expenses ($304 versus $512).

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Number 24 February 2002

From 1990 to 1997, households earning over $50,000 annually enjoyed a 38% reduction in medical and drug spending (see table), that contributed to a net reduction of 4% in their health care expenses. This is directly attributable to the shift from indemnity insurance to managed care. While most Americans experienced this shift, higher income families benefited most because of their spending patterns under indemnity insurance. Higher income households, better able to afford out-of-pocket expenses, were probably more likely to have obtained preventive services not covered by indemnity insurance, and to have used doctors who charged higher than average fees. Since managed care plans cover preventive services and prohibit balance billing, out-of-pocket spending was reduced more for high income households than all others because they no longer paid out-of-pocket for these expenses.

Out-of-Pocket Spending Trends by Income 1990, 1997

	1990	1997	% Change
Medical and Drug Expenses			
Higher Income	$732	$452	-38%
Lower Income	$424	$392	-8%
Premium Expense			
Higher Income	$600	$832	39%
Lower Income	$508	$676	33%
Total Expenses			
Higher Income	$1,332	$1,284	-4%
Lower Income	$932	$1,072	15%

Source: Bureau of Labor Statistics via Gabel and Ginsburg

In contrast, households earning $20,000 to $50,000 spent a substantial 15% more in 1997 on premiums and medical expenses than in 1990. Therefore, while Americans with employer based health insurance spent only 4.2% more for health care in 1997 than in 1990, lower income families' expenses increased more than three times that amount.

Some Consumers Elect to Spend More

While most insurers increased premiums sharply after 1997, a strong national economy lasted through early 2001 that helped consumers afford not only their rising contribution to premium, but also a variety of elective health services. Three categories of services (alternative therapies, cosmetic surgery, and refractive eye surgery) fall outside the coverage of all but the most generous plans, and yet thrived despite consumers footing the bills entirely out-of-pocket.

Alternative Therapies—So-called alternative therapies are a variety of services originally associated with non-Western medicine whose appeal has since spread broadly. A survey estimated that in 1997 Americans spent $12.2 billion out-of pocket on visits to alternative therapists and an additional $14.8 billion on herbal remedies and other products related to alternative therapies. This $27 billion is comparable to the estimated out-of-pocket expenses for all US physicians' services in 1997.[5]

Cosmetic Procedures—The aging of the baby boom generation and a strong economy fueled an upsurge in consumer spending for cosmetic procedures. In 2000, more than 1.3 million people (triple the number in 1992) had procedures performed by board-certified plastic surgeons. The most popular procedures were liposuction, breast augmentation (despite well publicized litigation over leaking silicone), eyelid surgery, and face-lift. Twenty-three percent were repeat patients and 38% had more than one procedure at the same time. Surgeon charges ranged from $3,000 for upper and lower eyelid surgery to $5,000 for a face-lift, for a total of $7.5 billion spent out-of-pocket by consumers in 2000, not including hospital charges.[6]

Refractive Surgery—Eye surgery such as radial keratotomy and LASIK corrects visual acuity with the objective of reducing or eliminating the need for glasses and contact lenses. In 1999, there was

a 98% increase in these procedures from the previous year, down slightly from a 104% increase in 1998. In 2000, consumers spent almost $2.5 billion out-of-pocket on refractive surgeries.[7]

The Market for Non-Covered Services

Medical services not covered by health insurance follow a for profit business model. Like any other luxury good, these services compete for discretionary income and usage varies with the strength of the economy. As noted in *Refractive Market Perspectives*, "costly zero interest financing plans initiated by leading auto makers may be shifting limited discretionary spending towards new car purchasers [and away from LASIK surgery]." In fact, in large part due to the slowing economy, the number of Americans undergoing elective vision surgery decreased in the second and third quarters of 2001 compared with the first quarter of 2001.

Practitioners who rely primarily on the self-pay market and provide an expensive service such as orthodontia, cosmetic or refractive surgery, routinely offer payment plans, free consultation and accept credit cards. Some practitioners also advertise directly to consumers; again, according to *Refractive Market Perspectives*, "Consumer demand [for laser surgery] was fueled by record spending on patient marketing including the industry-wide average spending of $200 per procedure on direct marketing."

As providers felt the pinch of reduced revenue from insurers, some diversified their businesses to incorporate a high-end, self-pay market, along with or replacing their traditional lines of business. Examples include the widespread introduction of cosmetic teeth whitening by dentists and tattoo removal by laser surgeons. At the institutional level, well known hospitals from the Mayo Clinic to Massachusetts General Hospital routinely solicit and treat wealthy self-pay patients from other parts of the US and abroad.

The newest luxury offering for the high-end, self-pay market is the high profile medical practice about to be opened by two former Beth Israel physicians. For $4,000 a year, in addition to the insurer reimbursement for individual visits, this practice will provide 24 hour access and highly individualized service to a small group of patients. Other practices have ceased to contract with insurers of any type. While restricting a medical practice to private self-pay patients has been called "a return to old fashioned medicine,"[8] it is the more personalized service that is old fashioned, not its cost.

Lack of Consistent Data Hinders Policy Making

Given the huge amount of money consumers spend out-of-pocket for health care services, too little is known about these expenditures. The CES does not offer enough detail on spending by income level nor does it differentiate between spending on services that are medically necessary and those that are elective. Moreover, consumers themselves have very short memories about their expenses, with barely a third of them able to recall for a surveyor even their family's steady contribution to their insurance premium.[9]

This lack of adequate data makes it difficult to assess people's capacity to pay more of the cost of their covered care, as they surely will be asked to do if costs continue to rise. It seems clear from the $37 billion spent on just three elective services that some people do have the ability, if not the willingness, to pay more for the covered services they use. Many experts contend that ever rising health care costs nationally are due in part to the insulation most Americans have had from the cost of the choices they make for these services. If they become more financially engaged, it could have the salutary effect of causing a slow down in the rise of health care costs.

The Role of Employers

In most companies, the range of earnings is quite diverse, yet employers tend to subsidize premiums equally or sometimes even more generously for their highest paid employees. By contrast, Harvard University uses an innovative strategy that most heavily subsidizes the premiums of employees earning $55,000 or less annually with the explicit aim of increasing the take-up rate of its lowest paid workers. Employers striving to continue offering health insurance despite rising premiums, would do well to introduce out-of-pocket policies that influence consumer behavior rather than just share cost. Employers must seek a balance in strategy that will not deter low income workers from accepting health insurance and accessing needed care, while encouraging higher income workers to assume more responsibility for the health care choices they make.

For more information on health care spending by the insured, types of employee out-of-pocket expenses, and their treatment under tax law, please see the previous issue of Healthpoint, "Out-of-Pocket Spending for Health Care Services."

Endnotes

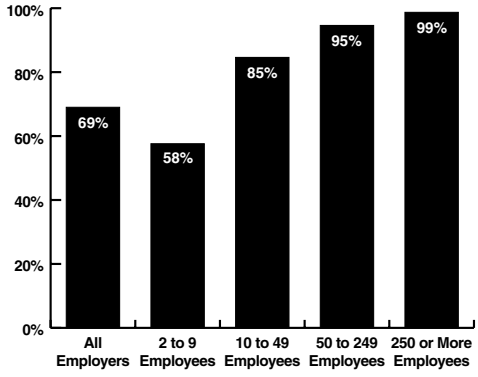
1. Patrick Martin, "Half of US Bankruptcies Caused by Medical Problems, New Study Finds," World Socialist Web Site, April 28, 2000, www.wsws.org
2. American Society of Plastic and Reconstructive Surgeons, Inc., Arlington Heights, Ill, www.plasticsurgery.org
3. Jon Gabel and Paul Ginsburg, "Trends in Out-of-Pocket Spending by Insured American Workers, 1990-1997," *Health Affairs*, March/April 2001. All data cited from CES study comes from this analysis.
4. Consumer Expenditure Survey (CES) is a yearly survey by the US Bureau of Labor Statistics. The survey includes information from 7,500 households using interviews and diary entries to document out-of-pocket expenditures.
5. David Eisenberg, MD et al, "Trends in Alternative Medicine Use in the United States, 1990-1997: Results of a Follow Up National Survey," *JAMA* Vol 280 (18) November 1998.
6. See endnote #2.
7. Market Scope, *Refractive Market Perspectives*, November 2001, Vol 6, www.mktsc.com
8. Gina Kolata, "For Those Who Can Afford It, Old Style Medicine Returns," *New York Times,* March 17, 2000.
9. Massachusetts Division of Health Care Finance and Policy, Health Insurance Survey of Massachusetts Residents, 1998 and 2000.

Did you know?

More Massachusetts Employers Offer Health Insurance

In a recent survey of 1,100 Massachusetts employers, the Division of Health Care Finance and Policy found that 69% of all private sector establishments offer health insurance to their employees. This is considerably higher than the national offer rate of 59% found by the US Medical Expenditure Panel Survey in 1999. A high rate of employer offered insurance is correlated to at least two factors characteristic of Massachusetts: high per capita income and a high proportion of large employers. Per capita income in 2000 was $37,710 in Massachusetts compared to $29,451 nationally. In addition, Massachusetts has a greater proportion of employers in every size category above 20 employees than does the nation as a whole. For additional results from the employer survey, please visit www.mass.gov/hrsa.

Percent of Private Sector Establishments Offering Health Insurance, by Size (2001)



Source: Division of Health Care Finance and Policy

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